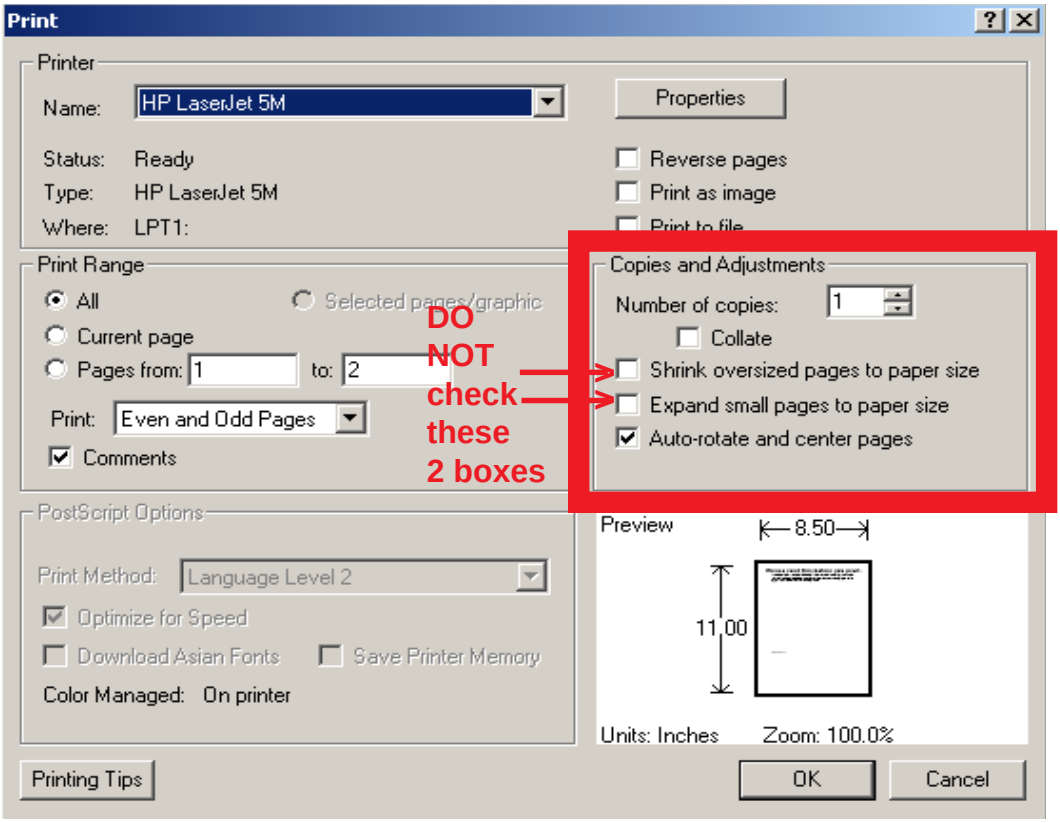
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Audiologist License Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Hearing and Speech—Audiologist

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 654-015 (REV 7/2004)

1A 0216020000 00286

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Audiology Application Instructions

Licensure and Interim Permit

Licensure Requirements

To qualify for licensure as an Audiologist in the state of Washington, one must have:

- Master's or doctoral degree or their equivalents from an institution offering a board approved program.
- Completion of postgraduate professional work experience consisting of thirty-six weeks full-time experience or part-time equivalent. Professional experience of less than 15 hours per week does not meet the requirement.
- Completion of the National Examination with a score of 600 or greater.
- Completion of a minimum of four clock hours of AIDs education.

General Instructions

All applicants must submit:

Completed Washington Audiology application form. Application without fees will not be processed. **Fees are not refundable.**

– Official transcripts must be sent directly to this office from the institution where the degree was earned.

– Proof of completion of the National Examination in Audiology with a score of 600 or greater.

– Professional Reference Form completed by your postgraduate supervisor.

OR

– Written verification of Clinical Competency in good standing from the American Speech and Hearing Association (ASHA) or Board certification from the American Board Audiology (ABA) will be accepted in lieu of official transcripts, National Examination score, and professional reference form. Written verification must be sent directly from ASHA or ABA to the Department of Health, Hearing and Speech Program.

Applicants licensed or certified in another state or jurisdiction requesting endorsement must complete the upper portion of the Out of State Verification of Certification/Licensure form and forward the form to the jurisdiction of licensure or certification for completion of the remainder of the form. The licensing agency may then forward the form to the Department of Health, Hearing and Speech Program.

Interim Permit Requirements

To qualify for an interim permit as an Audiologist in the state of Washington, one must have:

- Master's or doctoral degree or their equivalents from an institution offering a board approved program.
- Practice under the supervision of a Washington State licensed audiologist.
- Completion of a minimum of four clock hours of AIDs education.

General Instructions

All applicants must submit:

Completed Washington Audiology application form. Application without fees will not be processed. **Fees are not refundable.**

– Official transcripts from the program where degree was earned must be sent directly from the institution to the Department of Health, Hearing and Speech Programs.

OR

– Written verification of Clinical Fellowship Year participation in good standing from the American Speech and Hearing Association (ASHA) will be accepted in lieu of transcripts. Written verification must be sent directly from ASHA to the Department of Health, Hearing and Speech Program.

Your supervisor must complete the Acknowledgment of Responsibility form. The completed Acknowledgment of Responsibility form must accompany the application.

Applicants licensed or certified in another state or jurisdiction requesting endorsement must complete the upper portion of the Out of State Verification of Certification/Licensure form and forward the form to the jurisdiction of licensure or certification for completion of the remainder of the form. The licensing agency may then forward the form to the Department of Health, Hearing and Speech Program.

Licensure and Interim Permit Fees

The following fees must accompany the application for **licensure**:

Application Fee $125.00

Licensure Fee 100.00

Total **$225.00**

The following fees must accompany the application for **interim permit**:

Application Fee $125.00

Interim Permit Fee 100.00

Total **$225.00**

Check or money order may be made payable to the Department of Health. **All Fees are non-refundable**.

Further questions regarding applications should be referred to:

Send application and fee to:

Department of Health
Board of Hearing and Speech
PO Box 1099
Olympia WA 98507-1099

Send all supporting documents to:

Department of Health
Board of Hearing and Speech
PO Box 47869
Olympia WA 98504-7869
(360) 236-4914
(360) 236-2406 Fax

Please type or print clearly on all application forms. The address entered on the application form is your address of record. All correspondence will be sent to this address and it will appear on your license or interim permit.

The application process is considered confidential. Information about a pending application will only be provided to 1) the applicant, 2) any person appointed **in writing** by the applicant.

The current address and telephone number of a health care provider governed under chapter 18.130 RCW is not releasable as public information.

Renewal Information or Application Packets:

Customer Service Center ..... (360) 236-4700

For the Hearing Impaired, please call ..... (360) 664-0064

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
VALIDATION	DATE RECEIVED
LICENSE #	ISSUANCE DATE

LICENSE #

Application For Audiologist

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY | STATE | ZIP | COUNTY

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)
( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
— —

GENDER ☐ Female ☐ Male | BIRTHDATE (MO/DAY/YEAR) | PLACE OF BIRTH (CITY/STATE) | MAIDEN NAME

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list full name(s):

If presently employed by a Fitter/Dispenser or Licensed Audiologist, please provide the following (Required if applying for Audiologist Interim Permit):

BUSINESS NAME

ADDRESS

CITY | STATE | ZIP | COUNTY

Are you currently or have you previously been licensed in WA State as a Hearing Aid Fitter/Dispenser? ☐ Yes ☐ No

2. License/Permit Applying For:

Please indicate which of the following you are applying for:

☐ Audiologist License
☐ Audiologist Endorsement License
☐ Audiologist interim Permit

3. Previous Licensure or Certification

List all states where certificate(s) or licenses are or were held. (Previous credential to include license, certification or registration.) Specifically list all certificate(s) or licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if certificate(s) or license is current.

STATE/JURISDICTION	PROFESSION	CERTIFICATE OR LICENSE TYPE	CERTIFICATE OR LICENSE		METHOD OF CERTIFICATION OR LICENSURE	ACTIVE	INACTIVE
			YR ISSUED	NUMBER			

4. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

5. Agent Registration **(Contact Person)**

Pursuant to RCW 18.35.230, each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business; your attorney; or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

The registered agent may be released at the expiration of one year after the license issued under this chapter has expired or been revoked if no legal action has been instituted against the license holder.

Name of Registered Agent _____

Address _____

City _____ State _____ Zip _____

6. Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 X 11 sheets if necessary.)

FULL NAME, CITY AND STATE SCHOOLS ATTENDED	DEGREE EARNED	ATTENDANCE	
		ENTRANCE DATE	ENDING DATE

7. Professional Experience

INDICATE NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	INCLUSIVE DATES OF EXPERIENCE	
	ENTRANCE DATE	ENDING DATE

8. Bonding Requirement

RCW 18.35.240 Every establishment engaged in the fitting and dispensing of hearing instruments shall file with the department a surety bond in the sum of ten thousand dollars, running to the state of Washington, for the benefit of any person injured or damaged as a result of any violation by the establishment's employees or agents of any of the provisions of this chapter or rules adopted by the director.

In lieu of the surety bond required by this section, the establishment may file with the department a cash deposit or negotiable security acceptable to the department.

I, _____ , do hereby certify that I am covered by Security Bond
APPLICANT'S NAME

Number _____ , with _____ ,

Surety Company, whose Agent is _____ at

_____ , _____ , _____
AGENCY ADDRESS CITY STATE

_____ .
ZIP

Signature of Applicant _____ Date _____

9. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

10. Applicant's Attestation

I, _____ , certify that I am the person described and identified
NAME OF APPLICANT

in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Acknowledgment of Responsibility
Audiology Interim Permit

To the Supervisor:

Please review **RCW 18.35.060 (6)** and **WAC 246-828-045**.

To supervise a permit holder, you must be licensed in Washington state and in good standing. You shall provide supervisory activities as outlined in WAC 246-828-045. **All purchase agreements in the sale of hearing instruments must be signed by the supervisor or a licensed hearing instrument fitter/dispenser (as delegated by the supervisor) and permit holder.**

Upon the completion of each segment of the interim experience you must submit a copy of the Segment Certificate of Completion Form or the Clinical Fellowship Skills Inventory Audiology (CDSI-AUD) to the Department of Health, Hearing and Speech Program.

Should you desire to terminate your responsibilities as supervisor you must provide written notice immediately upon termination. You remain responsible for the permit holder until such a time as the notification of termination to the department is deposited in the U.S. mail

Please complete the following documentation and return to the Department of Health

Acknowledgment of Responsibility—to be completed by Supervisor

I, _____ , a licensed Audiologist in the State of Washington with
NAME OF SUPERVISOR

certificate number _____ , acknowledge that a I will take full responsibility for all

acts of _____ in connection with audiology and hearing instrument

fitting and dispensing services provided while under my supervision.

I further certify that the individual named above is covered by the _____
NAME OF AGENT

_____ . Surety Bond number_____ with_____

_____ Surety Company Agent is _____
NAME OF AGENT

at _____ , _____ , _____ _____
AGENCY ADDRESS CITY STATE ZIP

_____ _____
SIGNATURE OF SUPERVISOR DATE

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4914

Professional Reference Request

To be completed by Post-Graduate Supervisor

Please Type or Print Clearly.
Please be advised that upon receipt of written request, this form will become a public document.

TO	ORGANIZATION
POSITION	ADDRESS
CITY	STATE / ZIP

_____ , has applied for certification as an Audiologist/Speech Language Pathologist in the State of Washington. We would appreciate your completion of this reference form and return directly to:

Hearing and Speech Program
P.O. Box 47869
Olympia, WA 98504-7869

1. Relationship to Candidate: ☐ Post-Graduate Supervisor ☐ Other (specify) _____
   Appropriate dates of this relationship.: From _____ To _____
   Percent of applicant's time spent in audiology/speech pathology work: _____
   Title of applicant's position and name of organization: _____
   _____
2. Describe briefly the applicant's duties as you know them in the position listed above: _____
   _____
   _____
3. Please comment on the applicant's professional judgment, responsibility, integrity and relationships with professional peers and clients: _____
   _____
   _____
4. If you were a supervisor of the applicant's post-graduate work, please complete the following:
   A. Dates of post-graduate supervision: From _____ To _____
   B. Total number of hours of post-graduate audiology/speech pathology work you supervised (this should be a number and not a percentage):_____
   C. Total number of hours of face to face supervision you provided (This should be a number and not a percentage):_____

   (Applicants are required to have thirty-six weeks of full-time professional experience or part-time equivalent)

5. Please check the areas in which you judge the candidate to be technically competent and able to meet reasonable standards in the profession of audiology/speech pathology. Please double-check what you regard as the applicant's specialty area(s):

   ☐ Audiology ☐ Speech Language Pathology ☐ Medical ☐ Education ☐ Other

6. Do you feel that the candidate is a credit to the profession of audiology/speech pathology? ☐ Yes ☐ No

   Please explain: _____

7. Do you have any reservations against recommending the applicant for certification in the state of Washington for independent practice? ☐ Yes ☐ No

   If Yes, please comment specifically. Include any other information you consider relevant: _____

   _____

   _____

8. Is there any other information about the candidate which you believe should be provided to the Board of Hearing and Speech? ☐ Yes ☐ No If Yes, please explain: _____

   _____

   _____

   _____

   _____

   _____

I have carefully read the questions in the professional reference form. I have answered them completely, without reservations of any kind, and I declare under penalty that my answers and all statements made by me herein are true and correct.

Signature _____ Date _____

Your Name (please print) _____ Telephone _____

Highest degree earned _____

Licensed Audiologist ☐ Yes ☐ No State(s) _____ Yr. Cert. _____ Cert # _____

Licensed Speech Path ☐ Yes ☐ No State(s) _____ Yr. Cert. _____ Cert # _____

SEAL

_____

Subscribed and Sworn to before me this _____

Day of _____ , 20_____

Notary Public in and for the

State of _____

Residing at _____

Thank you very much for your cooperation.

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Out of State Verification of Certification/Licensure as an Audiologist

To Applicant:

Please complete this section. Forward this form to the jurisdiction of certification/licensure for them to complete and return to Department of Health, Hearing and Speech Program, PO Box 47869, Olympia, WA 98504-7869.

I, _____, am certified/licensed in the state of_____ ,

my certificate/license number is _____ . I have applied for a Washington State Audiologist Certificate. I authorize the release of the information request below to the Washington State Hearing and Speech Program.

Signature _____ Date _____

To The State Board:

Please provide **a copy of the current statute** under which the above named applicant is certified/licensed. Please return this completed form with the statute to the Department of Health, Hearing and Speech Program, PO Box 47869, Olympia, WA 98504-7869. Thank you.

I hereby certify that _____ was granted professional certificate/license number _____ to practice audiology in the state of _____ on the _____ day of_____ 20 _____ on the basis of:

	Yes	No
Successfully passing the National Examination in Audiology.	☐	☐
Successfully passing a state/local jurisdiction examination in audiology.	☐	☐
Successfully passing the International Hearing Aid Society examination in hearing instrument fitting/dispensing.	☐	☐
Successfully passing a state/local jurisdiction examination in hearing instrument fitting/dispensing.	☐	☐

Status of Certification/Licensure: ☐ Active ☐ Inactive ☐ Expiration Date _____

Legal or Disciplinary Action?: ☐ Yes ☐ No If yes, please explain below and provide any applicable documentation.

_____

_____

State Seal

_____ _____
SIGNATURE OF VERIFIER DATE

_____
TITLE OF VERIFIER